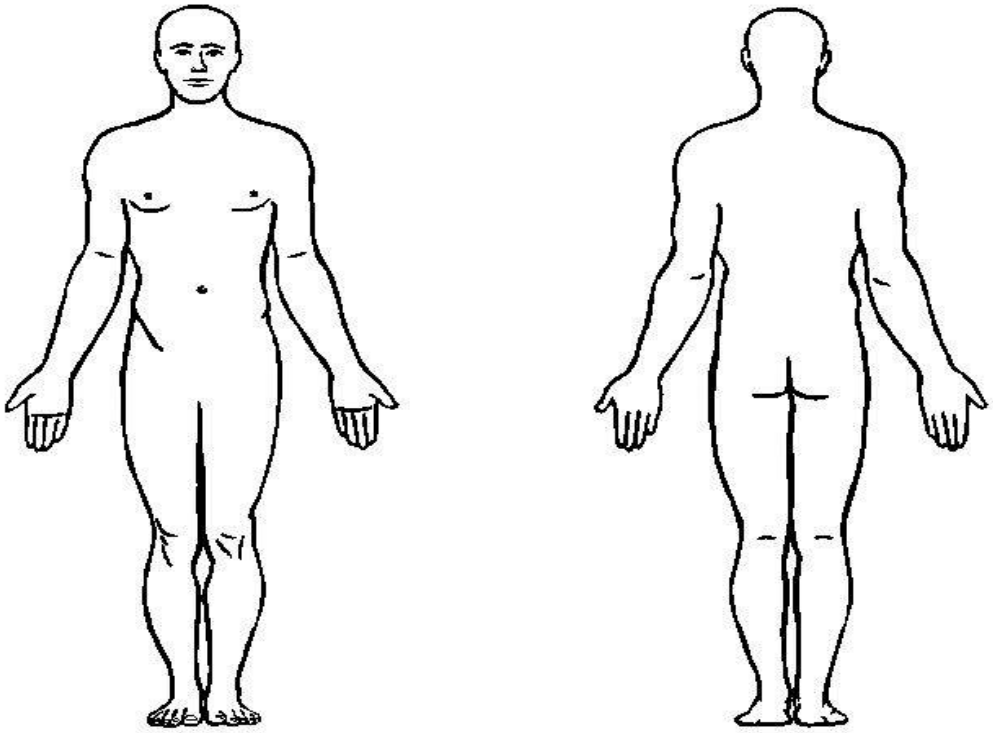
GENERAL NEW PATIENT FORM

Please print all information. All blanks must be filled to allow us to serve you quickly and efficiently. Thank you for your cooperation.

Date: _____ Last Name: _____ First: _____ MI: _____
Address: _____Apt#:_____City:_____State:_____Zip code:_____
❑ Male ❑ Female Date of Birth: _____ Age: _____ Height: ___ _____ Weight: __ _____ ___
SSN:_____
Phone: Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____
Email: _____
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Partner
Race: ❑African American ❑ Asian ❑ Hispanic/Latino ❑ American Indian ❑ Caucasian
❑ Other_____ ❑ Refused Ethnicity: ❑Hispanic ❑Non-Hispanic
Current Work Status: ❑ Full time ❑ Part time ❑ Retired ❑ Disabled (Since_____)
❑ Student ❑ Homemaker ❑ Unemployed Company Name: _____
Occupation: _____ Title:_____ How long have you worked there?_____
Referring Physician: _____ Phone: ( )_____ Primary Care Physician: _____

Please indicate where your pain is on the illustrations below.



Goals of visit:

_____

_____

History of Present Complaint

- How long have you had this problem? _____ Since: _____/_____/_____
Month Day Year

- Briefly, please give the details of your main problem: _____

_____

- Have you had spinal surgery in the past: (Check one) ❑ Yes ❑ No If so, what surgery was performed and when?_____ Did you improve from your procedure?_____

- Was this injury from ❑ Auto ❑ Work ❑ Other **If Work related, please fill out questions below. If not skip, to Medical/Surgical History** - Have you missed any work because of this problem? ❑ Yes ❑ No How much?_____

❑ Full time ❑ Part time Date of Injury: _____ Claim Number: _____

Allowed Conditions_____

Name of Managed Care Organization (MCO): _____Phone:_____

Address: _____ Contact_____

Employer at time of injury _____Contact: _____Phone: _____

Is there a C-9/prior authorization to see one of our doctors? ❑ Yes ❑ No Do you have an attorney? ❑ Yes ❑ No

If yes, please provide Attorney's Name and Phone:_____

Medical / Surgical History

Please choose all current and past medical conditions

❑ No Medical problem
❑ High Blood Pressure
❑ Heart attack/❑Heart Disease
❑ Heart failure
❑ Abnormal heart rhythm
❑ Lung Disease
❑ Tuberculosis
❑ Asthma
❑Bronchitis
❑ Emphysema
❑ Liver disease
❑ Hepatitis
❑ Diabetes ❑ type I / ❑ type II
❑ Thyroid disease
❑Stomach Ulcers/❑GastricReflux
❑ Irritable Bowel
❑ Stroke
❑Seizures
❑ Cancer – where?_____
❑Kidney Failure
❑ Kidney stones
❑ Osteoporosis / q Osteopenia
❑ Osteo-Arthritis
❑ Rheumatoid Arthritis
❑ Bleeding disorders
❑ Anemia
❑ Blood clots in legs/lungs
❑ Endometriosis
❑Ovarian cysts
❑ Anxiety
❑ Depression
❑ Schizophrenia
❑ Anorexia/bulimia
❑ Alcoholism
❑ Seen a psychiatrist
❑ HIV

Are you under a doctor's care for any other medical condition? ❑ Yes ❑ No If yes, please explain

_____

Please choose all surgeries you have had

❑ Spine-Neck
❑ Spine-lower back
❑ Brain
❑Heart/❑Pacemaker/❑IV Filter
❑Angioplasty/❑Stent/❑Bypass
❑ Lung
❑ Gallbladder/❑ Stomach
❑ Appendix/❑ Intestine
❑Hernia/❑Colon/❑Rectum
❑Hysterectomy/❑C-section/❑Female
❑Kidneys/❑Bladder/❑Urinary
❑ Prostate
❑Shoulders/❑Arms/❑Hands
❑Hips/❑Knees/❑Legs/❑Feet
❑ Eyes
❑ Ears
❑ Nose
❑ Throat
❑Other_____
_____
_____

Allergies	
Substance	**Reaction**

All Current Medications	
Name	**Dose**

Social History

-Current Work Status ❑ Working regular duty ❑ Working restricted duty (Since_____)

Number of Children: _____ I Live: ❑ Alone ❑ With: _____

- I live in a: ❑ House ❑ Apartment ❑ Assisted living ❑ Nursing home

- Are you a cigarette smoker? ❑ Yes, now ❑ Never ❑ Quit – How long ago did you quit?_____

If you answered "yes" or "quit", how much do or did you smoke per day? Check One below.

❑ Less than ½ pack ❑ ½ pack ❑ ¾ pack ❑ 1 pack ❑ More (How many? ____

How old were you when you started smoking? ___

- Do you drink any alcoholic beverages? (Check one) ❑ None ❑ Occasional ❑ 1 to 3 drinks per month

❑ 1 - 2 drinks per week ❑ 1 - 2 drinks per day ❑ 3 - 5 drinks per day ❑ More than 5 drinks per day How Many?____

- Alcoholic in past? ❑ Yes ❑ No

- Have you ever had a problem with drug dependence? ❑ Yes ❑ No

- Are there any law suits pending or contemplated related to you problem? ❑ Yes ❑ No

- If yes, please give your attorney's name and phone number:_____

- Please write any additional information that you feel is important for us to know

_____

_____

_____

Family History

What illnesses run in your close family (other than yourself)?

- ❑ Scoliosis
- ❑ Spine disease
- ❑ Arthritis
- ❑ Heart Disease
- ❑ High blood pressure
- ❑ Diabetes
- ❑ Cancer
- ❑ Bleeding disorder
- ❑ Mental illness
- ❑ Alcoholism
- ❑ Kidney disease
- ❑ Other_____

Review of Systems

Please check off any <u>current or recent</u> problem you have

GENERAL
- ❑ Unexplained weight loss
- ❑ Appetite change
- ❑ Fevers or chills
- ❑ Night sweats
- ❑ Marked fatigue
- ❑ Difficulty sleeping

EAR, NOSE, THROAT
- ❑ Difficulty swallowing
- ❑ Hoarseness
- ❑Loss of hearing
- ❑ Ear pain
- ❑ Nosebleeds
- ❑ Gum trouble

EYES
- ❑ Glasses
- ❑Change of vision

CARDIOVASCULAR
- ❑Heart or chest pain
- ❑ Abnormal heartbeat
- ❑ Poor heart function

LUNG
- ❑ Morning cough
- ❑ Shortness of breath
- ❑ Productive cough or sputum

DIGESTIVE
- ❑ Nausea or vomiting
- ❑ Stomach pain or ulcers
- ❑ Heartburn/acid stomach
- ❑ Frequent diarrhea
- ❑ Frequent constipation
- ❑ Uncontrolled loss of stool
- ❑ Blood in stool
- ❑ Hemorrhoids

SKIN
- ❑ Frequent rashes
- ❑Frequent itchiness
- ❑Easy bruising
- ❑ Swollen ankles

NEUROLOGICAL
- ❑ Seizures
- ❑ Blackouts/fainting
- ❑ Tremor
- ❑ Headaches/migraines

MUSCULOSKELETAL
- ❑ Joint Pains/Swelling
- ❑ Back Pain
- ❑ Neck Pain
- ❑ Muscle Aches

GENITOURINARY
- ❑ Burning on urination
- ❑ Difficulty starting urination
- ❑ Incontinence
- ❑ Pelvic pain
- ❑ Urinate at night more than once
- ❑ Unable to completely empty bladder

PSYCHIATRIC
- ❑ Depression
- ❑ Nervous exhaustion
- ❑ Anxiety
- ❑ Paranoia
- ❑ Obsessive/compulsive behavior

Insurance Information

Primary Insurance:_____ ID#: _____ Grp#:_____

Card Holder Name: _____ Date of Birth: _____ Relationship to Cardholder: _____

Secondary Insurance: _____ ID#: _____Grp#:_____

Card Holder Name: _____ Date of Birth: _____ Relationship to Cardholder:_____

HIPPA Disclosure

Your signature below acknowledges that our **Notice of Privacy Practice** is available to you upon request. The document is provided to you as proof of our ongoing efforts to protect your medical information and to keep that information confidential. As outline in the act, we may disclose you protected health information to persons directly involved with your health care.

_____ _____ _____

Signature of patient or representative *Relationship to patient* *Date*

May we leave a message on your recorder? ❑ Yes ❑ **No** **Cell Phone?** ❑ Yes ❑ No **Email?** ❑ Yes ❑ No

Please provide us with the names of your family/friends to which we are allowed to release your private medical information: _____ _____

Name *Relationship to patient*

For Personal Injury Claims that have an attorney please supply the name and phone below:

_____

Insurance Assignment and Release

The undersigned authorizes direct payment to Stephen D. Heis, M.D. & Associates, Inc. of my insurance benefits otherwise payable to or on behalf of the patient for all medical services. It is understood by the undersigned that ***he/she is financially responsible for the charges not covered*** by this assignment.

_____ _____ _____

Signature of patient or representative *Relationship to patient* *Date*